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GANGRENE OF LEG FOLLOWING DIPHTHERIA.*

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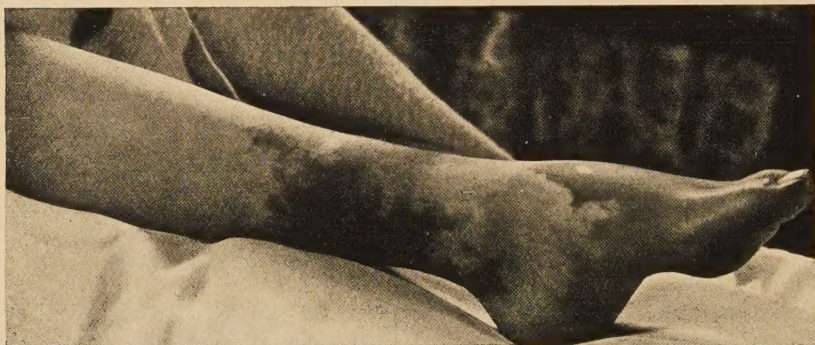
Assistant Medical Officer, Grove Fever Hospital, London.

A BOY, aged 13 years, was admitted to the Grove Hospital for diphtheria on June the 19th, 1910, the seventeenth day of disease. The acute attack had been mistaken for mumps by the father, and it was not until his brother had been infected that a doctor was sent for and Klebs-Loeffer bacilli were found in the throat. About a week before admission his voice had become nasal and he had had regurgitation of fluids through the nose. On admission the tonsils showed some opacity, but the throat was free of membrane. The voice was nasal. The knee- and ankle-jerks were active, and the plantar reflex was flexor. The heart was irregular. No antitoxin was given. The same evening the right leg from the knee downwards became cold, pale, and anæsthetic. The toes could not be moved, nor the ankle flexed. The plantar reflex was lost. The circulation was re-established in about four hours. During the next week the heart became much dilated and a loud mitral systolic murmur developed. Both liver and spleen were enlarged and tender. Albuminuria was present from admission till the thirty-fifth day.

* Case reported to the Section for the Study of Disease in Children of the Royal Society of Medicine, October the 28th, 1910.

On the twenty-first day both legs became cold, discoloured and numb. Pulsation was feeble in the posterior tibial and dorsalis pedis arteries. The boy also complained of tingling in both palms, but no alteration was detected in the radial pulses. On the following day the discoloration of the legs had gone. On the thirtieth day sudden pain occurred in the left leg, followed by discoloration. There was marked tenderness in the popliteal space, where the pulsation of the popliteal artery could not be felt. The femoral pulse was present in Scarpa's triangle. Gangrene rapidly developed in the left foot and leg. The photographs show the condition on the thirty-second day. The gangrene did not extend, and apart from the development of

FIG. 1.



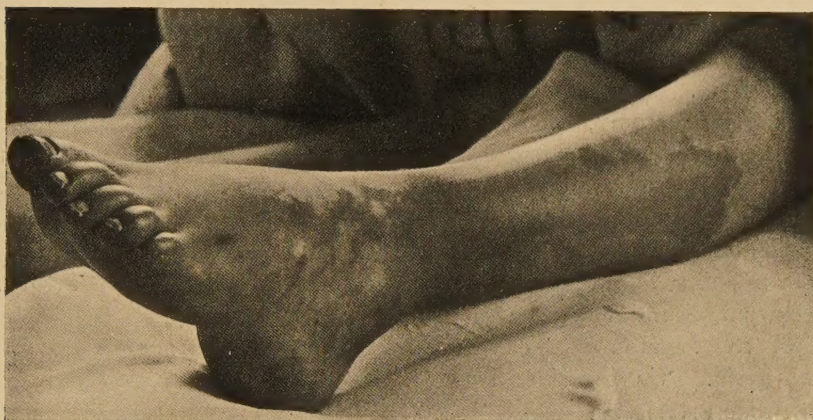
some bullæ was kept fairly dry and sweet by means of iodoform. On his transfer to Charing Cross Hospital, on August the 23rd, the eighty-second day of disease, the gangrenous area involved the whole of the left foot and extended on the inner side 4 in. above the lower end of the internal malleolus, on the outer side to $3\frac{3}{4}$ in. below the head of the fibula, and posteriorly to 7 in. below the popliteal space. There was still some cardiac dilatation, but the systolic murmur had disappeared. The blood-pressure, taken with C. J. Martin's modification of the Riva-Rocci sphygmo-manometer, from admission until the end of the fifth week was 80 mm. Hg., sometimes falling to 70; during the sixth week it ranged between 80 and 100, and in the seventh week and subsequently it was 100 to 96.

The voice was clear at the time of transfer, but the right knee- and ankle-jerks were lost. The vision had been frequently tested, but no ocular palsy had been detected. Amputation at the knee-joint was performed by Mr. H. S. Clogg on August the 29th, the

eighty-eighth day of disease, when an organising clot was found in the popliteal artery. Subsequent recovery was uneventful.

Gangrene of the extremities as a sequel of infectious disease is relatively rare, though its occurrence has been known since the time of Thucydides, who, in his description of the plague of Athens in 430 B.C., relates that some recovered after loss of their hands and feet (Bk. ii, c. 49). The nature of the Athenian epidemic has not been satisfactorily determined, though attempts have been made by medical historians to identify it with one or other of the acute infections, but not, so far as I know, with diphtheria. Estlander,

FIG. 2.



who regarded the epidemic as one of typhus, states that gangrene of the limbs was also noted in the typhus epidemics of the middle ages, and in the sixteenth, seventeenth, and earlier part of the nineteenth centuries.

Barraud, in 1904, in an exhaustive monograph on gangrene of the extremities in young persons after infectious disease, has collected 103 cases in patients up to the age of thirty, but only 29 of these were under fourteen, *i. e.* as young as my patient. Nine of these followed typhoid fever, 5 measles, 4 scarlet fever, 2 diphtheria, and 1 each of the following diseases: typhus, pneumonia, influenza, varicella, whooping-cough, tonsillitis, appendicitis, umbilical phlebitis, and acute gastro-enteritis. In 27 the gangrene involved the lower, and in 2 the upper extremities.

In addition to the two cases in Barraud's list following diphtheria recorded by Henoch and Rosenthal respectively, I have been able

to collect eight other cases of gangrene of one or more extremities following diphtheria, thus making a total of eleven, including the present case.

The following is a brief account of these cases arranged in chronological order. I have not been able to consult the original papers in which Cases 1, 2, 7 and 8 were described.

(1) 1875. Moroni's case. Gangrene of an extremity following diphtheria.

(2) 1878. Menzel's case. Gangrene of leg after faucial diphtheria; amputation at upper third of leg.

(3) 1879. Vedder's case. Boy, aged 8 years. Thirteen days after onset of severe faucial and nasal diphtheria gangrene of right leg developed, followed in three days by transient right hemiplegia and aphasia. Two days later pain in left leg. Death two days afterwards. No necropsy.

(4) 1883. Poupon's case. Girl, aged $7\frac{1}{2}$ years; laryngeal diphtheria, tracheotomy, albuminuria. Discharged in apparently good health fourteen days after admission. Re-admitted ten days later with great dyspnoea. Pulmonary embolism diagnosed. Signs of right popliteal embolism next day. Violet patches on right foot. Death on following day. Necropsy: Clot in femoral artery extending from opening in adductor magnus to middle of popliteal artery. Lungs not examined.

(5) 1890. Henoch's case. Boy, aged 8 years; very severe diphtheria. Gangrene of lower limbs. Necropsy: Thrombosis of both iliac arteries.

(6) 1890. Rosenthal's case. Girl, aged 2 years; severe diphtheria. Gangrene of both legs. Necropsy: Thrombosis of common iliac arteries.

(7) 1894. Munn's case. Embolus following diphtheria. Gangrene of left leg; amputation; recovery.

(8) 1894. Ward's case. Gangrene of left leg caused by an embolism the result of diphtheria.

(9) 1902. Breton's case. Girl, aged 3 years; moderate attack of diphtheria treated with antitoxin. Seventeenth day: Heart irregular; complete left hemiplegia and signs of thrombosis in left foot. Nineteenth day: Discoloured patches on right leg, ankle, and heel. Twenty-first day: Generalised convulsions. Twenty-third day: Nasal voice; another discoloured patch on metatarso-phalangeal joint of right hallux. Slough formed on heel, but other patches disappeared. Recovery.

(10) 1910. Bendix's case. Boy, aged 10 years; severe diphtheria;

extensive gangrene of right index and middle fingers; operation; recovery.

This list does not contain two cases of Raynaud's disease following diphtheria, one in a boy, aged 7 years, reported by Chevron, and the other in a man, aged 48 years, recorded by Powell. In another two cases signs of femoral embolism occurred, but death took place before gangrene had had time to develop, in a case related by Escherich, to be described below, and in the following case reported by Auché: Child, aged $4\frac{1}{2}$ years; severe faucial, nasal and laryngeal diphtheria; tracheotomy; repeated injections of antitoxin. After eight or nine days the general condition became worse and signs of embolism developed in the lower limbs. Death. Necropsy: Apical thrombi in both ventricles; very intense myocarditis and slight parietal endocarditis; Gram-positive diplo-streptococcus in endocardial clots. Two thrombi, one 5 cm. long in left external iliac and femoral arteries, the other $2\frac{1}{2}$ cm. long in the right femoral artery.

It is noteworthy that all the cases of gangrene of the extremities following diphtheria have occurred in children, in striking contrast to the gangrene following other infectious diseases, especially typhoid and typhus.

In the few cases in which the date of onset is given the gangrene is stated to have appeared in convalescence, as in the present case. In three cases there was evidence of multiple embolism, which probably also occurred in my case.

In most of the previous cases the character of the initial angina was severe. In the present case the throat was clean on admission to hospital, but a retrospective diagnosis of severe angina could be made on the following grounds: (1) The disease was mistaken by the father for mumps—an error frequently committed with disastrous results in the early stage of malignant diphtheria; (2) the occurrence of two phenomena almost exclusively confined to severe attacks, viz. early palatal palsy and enlargement of the liver; (3) though by no means conclusive, the character of the brother's angina is suggestive owing to the frequency with which severe attacks of diphtheria affect members of the same family. Thus in fifty-one out of 133 families, or in 38·3 per cent. suffering from diphtheria, I have noted that two or more members of the same family had an angina of equal severity.

Though recent research has shown that gangrene of the extremities following infectious disease is, as a rule, caused by autochthonous thrombosis due to acute arteritis—in only 10·7 per cent. of Barraud's

and 5·7 per cent. of von Wartburg's cases was there definite evidence of embolism—in the present case the origin of the gangrene was almost certainly embolic. In the first place there was a well-marked cardiac lesion. Secondly, emboli were also probably present in situations where primary arterial thrombosis is uncommon, viz. the spleen and kidneys, as well as in the femoral and popliteal arteries of the opposite limb, in which, however, the circulation was re-established. The excessive tenderness and enlargement of the liver were possibly due to hepatic embolism, but these signs are fully explained by the hepatomegaly which frequently accompanies severe diphtheria without any infarction, and is due partly to congestion and partly to fatty change. Thirdly, the diagnosis of embolism in diphtheria has frequently been verified at the necropsy. Thus in 59 post-mortem examinations I found infarcts in 7, or 11·8 per cent. In four they were situated in the lungs only, in one in the left kidney, in one in the liver, and in one cerebral embolism was associated with renal infarction.

In this connection it may be stated that cerebral embolism, which the present case fortunately escaped, is much more frequent in diphtheria than embolism of the extremities. Though some cases of post-diphtheritic hemiplegia, of which about seventy cases have been recorded, may have been due to thrombosis or encephalitis, in the great majority of fatal cases evidence of embolism has been found.

Escherich has recently published a case of a boy, aged 2 years, admitted to hospital on the sixth day of a severe attack of faucial diphtheria with broncho-pneumonia. Right hemiplegia developed the same day. The next day generalised convulsions occurred. On the eighth day the thighs became livid, cold, and devoid of sensation, and no pulse could be felt in the popliteal and dorsalis pedis arteries. Death took place the same day. The necropsy revealed a thrombus adherent to the ventricular surface of the mitral valve, embolism of the left middle cerebral artery, and softening of the left cerebral hemisphere. Emboli were also found in the left common iliac artery at its bifurcation and in the right femoral artery. Small recent infarcts were present in the right kidney and liver.

Other instances of embolism following diphtheria will be found in the writings of Professor Marfan and his pupils Deguy and Detot.

The sudden onset in this case, though suggestive, is not, as was once thought, pathognomonic of embolism.

The exact situation of the embolus which was the cause of the gangrene in this case it is impossible to determine. As stated above, an organising clot was found in the popliteal artery, but Mr. W. S. Fenwick, surgical registrar of Charing Cross Hospital, has kindly informed me that the lumen of the vessel was not obliterated, so that the embolus which was the cause of the gangrene must have been higher up.

Of the sixty-two cases collected by Barraud in which the site of the arterial obstruction was determined, unilateral femoral thrombosis was the commonest finding, being noted in thirteen cases, and was closely followed by unilateral popliteal thrombosis, which occurred in twelve cases. It is probable, however, as Barraud remarks, that the latter figure is too high, for in amputation cases which recovered no exact knowledge was obtained as to the extent of the thrombosis, which may, as in my case, have been present in the femoral as well as in the popliteal artery.

It is probable that the excessively low blood-pressure helped to prevent the establishment of a collateral circulation.

The prognosis in gangrene of the extremities following infectious disease is grave, but by no means hopeless. The mortality among Barraud's 103 cases was 51.6 per cent., but many of these date from the pre-antiseptic period. Of the 29 cases in children under fourteen years of age, 13 died, 11 recovered, and in 5 the issue was not recorded. Of the 8 cases following diphtheria in which I have been able to ascertain the issue, 4, including the present case, recovered and 4 died.

Prophylaxis is important, and should consist of large doses of antitoxin and prolonged rest in bed in severe cases of diphtheria. The history of this patient's brother furnishes an instructive example of the value of this treatment. He was admitted with severe angina on the seventh day of disease, when he received 16,000 units of antitoxin. Complete recovery took place, and no complication ensued beyond albuminuria and ciliary palsy. It is noteworthy that in only 1 of the 11 cases of gangrene following diphtheria, viz. that recorded by Breton, had antitoxin been employed.

Finally, I would draw attention to the fact that though more than eight weeks elapsed between the occurrence of the gangrene and the amputation, no harm resulted from the delay. An earlier operation was considered inadvisable owing to the boy's general enfeeblement and his cardiac condition. For the first fortnight following the onset of the gangrene the temperature ranged between 96° and 100° F., but subsequently it remained practically normal.

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A CASE OF CHLOROMA.

By FRED. TRESILIAN, M.D., F.R.C.P. Edin.

THE following account of a case of this rare and interesting disease is somewhat meagre, especially in regard to the earlier stages of the development of the typical signs. No actual notes were taken of the early history, and it is only owing to the kindness of my friend Dr. Distin, of Enfield, under whose care the child continued all through its illness, that I had the privilege of seeing the child on two or three occasions with him.

The boy, William S—, was aged 6 years, and the illness commenced in November, 1909, with complaint of pain in the left knee. In the middle of January, 1910, he was admitted into Enfield Cottage Hospital for circumcision, and while under an anæsthetic was found to have enlarged glands in the abdomen simulating plastic peritonitis. He was very nearly operated on for tabes

mesenterica. In February he showed enlarged glands in the axillæ and neck and growths on cranial bones, and he began to get anæmic. While in the hospital he had slight pyrexia.

March the 27th.—The condition was one of intense pallid anæmia, with no yellow tint of skin; the lips and mucous membranes quite

FIG. 1.



colourless. The eyes were prominent, the temples full, and there were hard swellings on the back of the head. Glands of neck, axillæ, and groins were distinctly enlarged, the axillary and cervical ones being very much so. There was a palpable enlargement of

FIG. 2.



FIG. 3.



the spleen. The child was very emaciated. There was an erratic temperature. There was no deafness, but the child complained constantly of pain in the left ear. He was quite conscious. Hæmic systolic bruits at apex. A blood-slide showed an abundance of large and small lymphocytes.

April the 12th.—The child is much worse, the anæmia more pro-

found and the emaciation extreme. No hæmorrhages of skin or gums. Glands in neck and axillæ in large masses, and four or five growths on cranium; temporal growths larger; marked proptosis and convergent strabismus. A chain of small glands above the left clavicle. Enlargement of veins in temples and on the sides of the face. The large distended veins on the intensely white skin are a striking feature. Swellings could be felt in the abdomen.

May the 3rd.—The child is very wasted. There are five large, bossy growths on the head and a large one on left temple with very distended veins over it, and also very distended veins on both temples, forehead, and sides of face. Other features the same but more in evidence. The child is both conscious and sensible. The child died on May the 23rd, quite conscious to the last. I append the report of the Clinical Research Association as to the blood condition, given on May the 4th, and also three photographs. Fig. 1 shows the child when well and before the disease appeared; Figs. 2 and 3 were taken about the same time as the blood report was given.

The clinical position of the disease is somewhat uncertain. The features exhibited show a marked resemblance to those of acute leukæmia, a disease by no means uncommon in children, in fact, the blood changes are identical in both. On the other hand the glandular enlargements place the disease somewhat close to lymphadenoma, a condition in which usually no blood changes of any consequence occur. It shows also a strong resemblance to lympho-sarcoma, which is also common in children, and would seem to be a clinical condition arising from a combination of this disease with acute lymphatic leukæmia.

Report of the Clinical Research Association.—Examination of this specimen of blood has given the following results: Hæmoglobin 89 per cent., red blood-corpuscles 1,300,000 per c.mm., or 26 per cent., white blood-corpuscles 21,000 per c.mm.

The red blood-corpuscles are irregular in size, several megalocytes and a few microcytes being present, while the average diameter is just over 9 μ . There is a moderate degree of poikilocytosis.

The hæmoglobin content varies considerably, as the stain is well retained by many of the cells, but others show a large central *delle* and intermediary forms occur. A few cells show a tendency to general basic staining (polychromatophilia), but punctate basophilia is not evident. Nine nucleated forms (756 per c.mm.) occur during a count of 250 leucocytes, and are classified as—megaloblasts 3 (252 per c.mm.), normoblasts 6 (504 per c.mm.).

The differential count of the white blood-corpuscles is: Polymorphonuclear neutrophiles 49·6 per cent., 10,416 per c.mm.; small lymphocytes 36·4 per cent., 7644 per c.mm.; large lymphocytes 4 per cent., 840 per c.mm.; eosinophiles 2 per cent., 420 per c.mm.; masts 0·8 per cent., 168 per c.mm.; myelocytes 7·2 per cent., 1512 per c.mm.

Degenerated forms of leucocytes are not seen, and the films give no evidence of any marked increase in the number of blood-platelets.

A CASE OF ACUTE INFECTIVE OSTEO-MYELITIS TREATED WITH VACCINE.

By A. G. L. READE, M.R.C.S.Eng., L.R.C.P.Lond.,

*Senior Assistant Medical Officer, the Children's Infirmary, Carshalton;
Late Senior House Surgeon, Radcliffe Infirmary and
County Hospital, Oxford.*

THERE are several points of interest in regard to the ætiology, diagnosis, and the treatment of this case, and I think it may be useful to record it.

The patient, a boy, aged 14 years, was admitted to the Children's Infirmary on August the 24th, 1909, suffering from early pulmonary tuberculosis. It was noted on admission that he was pale and thin, and that there was probably some consolidation at the apex of the upper lobe of the right lung. He was given the routine open-air and tonic treatment. His general condition slowly improved, the physical signs cleared up after two or three months, and the boy was about to be discharged when, on April the 21st, 1910, his temperature suddenly rose to 102° F., and he complained of pain in the right leg.

On examining the leg nothing abnormal was noticed except some tenderness round the knee-joint, but the patient was evidently seriously ill. He was somewhat drowsy and complained of considerable pain; the tongue was furred and the pulse rapid. The boy was reported to have been out in the wet grass, and for a time it was thought probable that he was suffering from subacute rheumatism. The next morning he was much better, but the temperature was still 102° F., and on the 29th the leg became swollen and extremely tender, and it was quite obvious that he was suffering from acute infective osteo-myelitis.

An incision was made over the front of the tibia, and on the

periosteum being divided a considerable quantity of pus escaped; the upper part of the tibia was bare, and the medullary cavity, on being opened with the chisel, was found to be filled with pus. The opening in the bone was enlarged to about four inches in length, a counter-opening made on the outer side of the calf, and a drainage-tube put through. A culture obtained from the pus showed a pure culture of *Staphylococcus pyogenes aureus*, and some of this was sent to the Metropolitan Asylums Board laboratories for a vaccine to be prepared.

On the following day the boy seemed more comfortable, but complained of pain in his left wrist. The patient was again anæsthetised, and I made an incision over the lower end of the ulna; the periosteum near the styloid process was found stripped off and the bone necrotic. The necrotic part was chiselled away and a counter-opening made through the front of the wrist.

The opsonic index at this time towards the *Staphylococcus pyogenes aureus* was found to be only .77. On May the 4th an injection was given hypodermically containing a quarter of a million cocci, sterilised by being mixed with $\frac{1}{2}$ per cent. carbolic acid and heated to a temperature of 60° C. for half an hour. The same night the temperature rose to 101.2° F., showing a slight reaction to the vaccine. A week later it was found that the opsonic index had risen to .86. Three eighths of a million cocci were given, and on the same night the temperature was 100.4° F., again showing slight reaction. On May the 19th, as the wrist was more swollen, the wound was enlarged and more necrosed bone removed. From this time onward the boy gradually improved. An increasing dose of the vaccine up to a dose of one hundred million cocci was given about every tenth day, and by June the 21st the wrist wound had healed. On July the 7th the opsonic index had risen to 1.35, and a week later the boy was allowed to get up. He is now (October the 18th) extremely well in general health and the leg is almost healed.

Remarks.—With reference to the diagnosis of this case, it is noteworthy that the general condition at first was considerably worse than was accounted for by the local signs. As to the ætiology, I have ascertained that two or three days before the commencement of his illness the boy had fallen down and slightly grazed his knee, the injury being so slight that it was not discovered, and no attention was paid to it by the patient. This was no doubt the exciting cause and possibly the site of entrance of the staphylococcus.

As regards treatment by vaccine, it is always difficult to say how far it does good, because one cannot form an opinion as to what

the progress of the case would have been had no vaccine been given. However, I think that two things are probable in this case. First, that the vaccine diminished the effect of the extreme toxæmia on the general condition of the patient. On a boy, aged 9 years, admitted to the Radcliffe Infirmary, Oxford, suffering from osteomyelitis of the tibia, I performed a similar operation, but the toxæmia so increased and his condition became so grave that it was not considered safe to leave the source of infection, and amputation became necessary. In the present case, on the other hand, the boy's general condition greatly improved a day or two after the first dose of vaccine.

Secondly, I think the vaccine increased greatly the rapidity of healing. It is not uncommon for patients to be transferred to the Children's Infirmary in whom discharging sinuses and necrosis of bone have persisted for years after the attack of acute osteomyelitis. For example, a boy, aged 15 years, who was recently discharged cured, had had the acute attack three and a half years before admission. In the present case the ulnar wound was healed four weeks after the operation, and the tibial wound at the time of writing (October the 18th) is practically well.

I am indebted to Dr. Carl Prausnitz, of the Metropolitan Asylums Board laboratories, for the determination of the opsonic index and preparation of the vaccine.

The Royal Society of Medicine.

SECTION FOR THE STUDY OF DISEASE IN CHILDREN.

Friday, October the 28th, 1910.

Dr. E. CAUTLEY, President, in the Chair.

A Case of Achondroplasia in a Girl, aged 5 years, was shown by Mr. W. HAMPSON for Dr. ERIC PRITCHARD. The appearance was typical and the height of the child was only 30 inches. Skiagrams showed defective ossification of the epiphyses of the long bones, with overgrowth of the cartilages. The patellæ were either absent or rudimentary and unossified. The child began to walk at the third year, and was healthy and intelligent.

A Heart Presenting Atresia of the Pulmonary Artery, Patent Foramen Ovale and Deficient Interventricular Septum was shown by Dr. T. R. WHIPHAM. The right side was hypertrophied, and the left

carotid artery arose from the innominate artery. The ductus arteriosus was obliterated. The patient, aged 1 year and 9 months, was shown on May the 27th, and presented marked cyanosis and clubbing of the digits. There was at that time a polycythæmia of 9,440,000 red corpuscles per c.mm. The number rapidly increased at the rate of 157,000 per c.mm. a day until a maximum of 12,740,000 with a hæmoglobin value of 200 per cent. was reached. At times there were no murmurs to be heard over the cardiac area, and at most there was but a faint systolic bruit in the pulmonary region. Death occurred suddenly during an attack of dyspnœa.

Dr. PORTER PARKINSON discussed the case.

Congenital Deformity of the Palate.—Dr. D. WOOD showed an infant, aged 5 weeks, with a cleft in the hard and soft palate, the cleft being occupied by new growths, projecting downwards into the mouth, which were of an uncertain nature.

Mr. P. L. MUMMERY made some remarks on the curious condition.

Sclerema Neonatorum.—Dr. F. LANGMEAD showed a case in an infant, aged 8 months. In the face the lines of expression were almost absent and the mouth gaping from stiffening of the cutaneous and subcutaneous tissues. The child, however, was able to suck. The skin all over the trunk was firm and inelastic, and the thighs and outer aspects of the calves were also affected. The latissimus dorsi and pectoralis muscles were firm and contracted. The X rays did not show any calcification of muscles. The knees and elbows were extended with difficulty. The hands were small and the fingers tapering and stiff at the interphalangeal joints. The feet were similarly affected to a less extent. The temperature showed a daily rise from 99° to 100° F.

Dr. PORTER PARKINSON and the PRESIDENT discussed the diagnosis of the case.

Tumour of Rectus Abdominis.—Mr. P. L. MUMMERY exhibited a girl, aged 5½ years, in whom a tumour on the posterior aspect of the left rectus abdominis muscle was first noticed about three weeks previously. This had almost disappeared under iodide of potassium. There were no other signs nor history of congenital syphilis. Wassermann's reaction had not been tried.

Mr. D. DREW remarked as to the treatment of the case and Dr. PARKES WEBER also spoke.

Injury to the Brachial Plexus.—Mr. DOUGLAS DREW showed a boy, aged 10 years, with injury to the right brachial plexus as the result of being crushed by a van-wheel. The arm presented a paralysis of the Duchenne-Erb type, with weakness of the extensors of the wrist and slight anæsthesia over the shoulder. The paralysed muscles showed the reaction of degeneration and had not regained power. A little above the clavicle some induration of the tissues could still be felt.

Mr. P. L. MUMMERY, in commenting upon the case, said that one cause which he believed operated in producing Erb's paralysis, but had not yet been mentioned, was the method of doing artificial respiration in the newly born infant, which consisted in holding the face away, with the thumbs over the clavicles, and throwing the child backwards over the head and down again. He saw a case of Erb's paralysis at hospital in which that method

was stated to have been done for three quarters of an hour, and the muscle was practically torn through. That danger should be put before those who did midwifery work.

Separation of the Lower Epiphysis of the Humerus.—Mr. DREW also showed a boy, aged 5 years, in whom a fall had caused a separation of the lower epiphysis of the humerus with displacement inwards. A skiagram showed that the epiphysis was attached to the inner side of the humerus by a large buttress of callus.

Gangrene of Leg following Diphtheria.—Dr. J. D. ROLLESTON showed charts and photographs of a case occurring in a boy, aged 13 years. The patient was not seen until the seventeenth day, no antitoxin having been given. Palatal palsy and albuminuria were present on admission to hospital. The same evening the right leg below the knee became cold and anæsthetic, and the plantar reflex was lost. Circulation was re-established in four hours, but during the next week dilatation of the heart ensued and a loud systolic murmur developed. On the twenty-first day there was temporary coldness and discoloration in both legs, and on the thirtieth day commencing gangrene of the left leg with obliteration of the pulse in the popliteal artery. Gangrene rapidly developed in the foot and leg and amputation through the knee-joint by Mr. Clogg was subsequently performed, when an organising clot was found in the popliteal artery. Recovery was uneventful. The gangrene was probably of embolic origin. Only ten other cases of gangrene of the extremities after diphtheria have been recorded.

Concurrent Scarlet Fever and Chickenpox.—Dr. J. D. ROLLESTON also showed charts and photographs of a boy, aged 8 years, who had been exposed to chickenpox three weeks previously, and was admitted with a typical scarlet fever throat and rash. On the following day the varicella eruption appeared. Subsequently there was a profuse desquamation and late cervical adenitis which confirmed the diagnosis of scarlet fever. The child made a good recovery.

A Female, aged $3\frac{1}{2}$ years, the Subject of Recurrent Tetany, was exhibited by Dr. G. A. SUTHERLAND. The attacks began seven months previously after prolonged indigestion and abdominal pain. A month later the abdomen was distended and tender, a fluid thrill being present. The symptoms subsided but recurred with pain in the hands and feet. The tetany was typical, facial irritability being marked at times and laryngeal stridor occasionally present. Von Pirquet's test was negative and there were no signs of active rickets.

Dr. LANGMEAD and the PRESIDENT discussed the case at length and Dr. T. R. WHIPHAM made some remarks.

A Case of Idiopathic Hypertrophic Dilatation of the Colon with Skiagrams was shown by Dr. J. B. MOLONY and Dr. H. D. ROLLESTON. The patient, a male, aged 3 years, had severe bilious vomiting when eight days old, but then remained well, though thin, till he was weaned at sixteen months; he then became subject to bouts of constipation lasting four or five days, with progressive abdominal distention. Medicine or enemas brought away large quantities of hard fæces and flatus. Later, although purgatives were taken daily, the bowels did not respond unless enemas were

given; the appetite was ravenous, but the child became very thin. There had been five or six attacks of specially obstinate constipation accompanied by bilious vomiting, which had never been stercoraceous. There had been numerous attacks of tympanitic distention without vomiting, which were relieved by the expulsion of wind. When admitted, during a minor attack of this kind, the boy showed very great tympanic distension of the abdomen with upward displacement of the heart and lungs. Peristaltic waves were observed passing along the course of the colon from right to left; as the wave progressed a V-shaped eminence, with its apex upwards, was seen to rise between the recti. A wave had also been observed to pass from left to right in the left hypochondrium and epigastrium, resembling that seen in hypertrophic stenosis of the pylorus, but probably due to displacement of the descending colon. The patient, who was poorly nourished (weight, 1 st. 10 lb.), was cheerful, and did not show any signs of pain when vigorous peristalsis was going on. There was no clubbing of the fingers. The urine contained indican, but not in large quantities. The distention varied, and after a long tube had been passed the abdomen sometimes appeared almost natural. The mother's relations were said to be markedly constipated; there were two other children, both in good health. Two drachms of bismuth carbonate in three ounces of milk were administered to the child, and screen examination immediately afterwards showed that the whole of the bismuth was high up under the left diaphragm, thus proving that the abdominal distension was not due to dilatation of the stomach. A skiagram from front was taken three and a half hours later, and showed that the bismuth was lining the walls of an enormously distended bowel, extending vertically on the extreme right of the abdomen, and that there was a transverse viscus of normal calibre across the upper part of the abdomen also containing bismuth. These appeared to be ascending and transverse colons respectively. The inference was that the stomach and small intestines had passed their contents on with at least normal rapidity. A skiagram taken from front twenty-four hours after bismuth had been taken showed some small amount of bismuth in the right iliac region and none elsewhere. After this skiagram was taken an indiarubber tube, with soft metal wire in it, was passed into the anus, and a length of about 8 in. passed freely, without obstacle, into the bowel. A skiagram taken from the front showed that the tube extended vertically upwards through the abdomen as far as the diaphragm, suggesting that the central distended gut, as seen on skiagrams, was rectum.

The PRESIDENT and Mr. P. L. MUMMERY discussed the case.

A Child, aged 4 months, with "Congenital Elephantiasis" of the Arm, was exhibited by Mr. C. T. DENT. There was probably extensive lymphangiectasis, so that the condition was allied to cystic hygroma. There was also superficial nævus so that there was a condition of cavernous angioma. The bones appeared normal in a skiagram, but were probably longer than in the corresponding limb.

Dr. PARKES WEBER remarked upon the case.

A Case of Congenital Insufficiency of the Soft Palate in a Girl, aged 9 years, was exhibited by Dr. L. GUTHRIE. Regurgitation of fluids through the nose occurred during the first five years of life, but not afterwards. The speech was marked rhinolalia, but was not intelligible until the patient was five years old. The soft palate was normal in appearance, but motion-

less on phonation and on stimulation. The condition was thought to be one of muscular insufficiency rather than of submucous cleft palate.

Congenital Heart Disease.—Mr. P. G. LEE sent a report of a case of deficiency in the interventricular septum and patent ductus arteriosus in a child, aged 7 years.

Philadelphia Pediatric Society.

MEETING, October the 11th, 1910, CHARLES A. FIFE, M.D., President.

Purpura.—Dr. THEODORE LE BOUTILLIER showed a boy, aged 2 years, of Italian parentage, breast-fed for eighteen months, although table food had also been given since he was a year old. He had had cervical abscesses at nine and again at eighteen months. He had had attacks of purpura ever since he was six months old, lasting two or three days at a time. There had never been hæmorrhage from any mucous membrane. Blood examination February the 9th, 1910, showed hæmoglobin 15 per cent., red cells 1,600,000, leucocytes 22,000; on June the 10th, hæmoglobin 25 per cent., red cells 4,128,000, leucocytes 30,600. He had had severe nasal hæmorrhages, but none since the last blood-count.

Dr. ELEANOR C. JONES referred to a case of purpura in a child which had up to the present time lasted six months, due to a streptococcic infection through the tonsils.

Leukæmia.—Dr. LE BOUTILLIER also showed a boy, aged 1 year, who had had bronchitis when eleven weeks old. He was one of twins, breast- and bottle-fed, in poor hygienic surroundings. His spleen was noted as enlarged and palpable March the 5th, with enlarged abdomen and marked pallor. He remained pale all the summer. In September he had an attack of diarrhœa, vomiting, and some cough, moderate jaundice, large tense abdomen, palpable spleen two fingers' breadth below the costal border, large liver, and œdema of the scrotum. He was admitted to St. Christopher's Hospital for Children October the 1st. Blood examination April the 10th showed hæmoglobin 40 per cent., red cells 660,000, leucocytes 16,000; July the 10th, hæmoglobin 35 per cent., red cells 445,000, leucocytes 24,100; and on October the 10th, hæmoglobin 35 per cent., red cells 300,000, leucocytes 28,100. Differential count gave polynuclears 27 per cent., mononuclears 43 per cent., lymphocytes 28 per cent. and basophiles 2 per cent.

Dr. E. E. GRAHAM called attention to the importance of making more blood examinations in cases of malnutrition.

Splenic Anæmia.—Dr. J. CLAXTON GITTINGS showed a girl, aged 20 months, who had had intestinal indigestion since birth. Her abdomen had always been large; there was no evidence of syphilis. The mother felt the "lump" in the abdomen twelve days ago, and brought her to the children's hospital seven days ago, with moderate rickets, head sweating, flatulent, distended abdomen, liver enlarged 1 cm. below costal margin, and spleen extending to the anterior superior spine of the ilium and to within 1 cm. of the median line. Blood examination May the 10th gave hæmoglobin 55 per

cent., red cells 3,460,000, leucocytes 13,000; on October the 10th, hæmoglobin 45 per cent., red cells 3,050,000, and leucocytes 16,680. Differential count was polynuclears 62.2 per cent., large mononuclears 4.6 per cent., small mononuclears 28.2 per cent., transitionals 8.9 per cent. and eosinophiles 4 per cent. in 13,680 leucocytes. She had digested her food well since admission, and the blood-findings thus far did not warrant the diagnosis of anæmia pseudo-leukemica infantum. The disproportion between the size of the spleen and the degree of the changes in the blood was the principal point of interest.

Delayed Crisis in Croupous Pneumonia.—Dr. GITTINGS showed a boy, aged 2 years, whose only previous illness has been bronchitis last May. He became ill September the 7th, suddenly, with vomiting, fever, malaise, dry, short cough, rapid breathing, and loose stools. Examination on admission showed consolidation of the entire right lung. Crisis occurred on the twenty-second day, and since then the temperature had not exceeded 100° F. During the period of pyrexia the physical signs remained practically unchanged, while the consolidation had almost completely disappeared since the crisis. This case will be reported later in full.

Tubercular Peritonitis.—Dr. GITTINGS also showed a coloured boy, aged 8 years, whose illness began a month ago with dull abdominal pains, worse after eating, and somewhat relieved by stools, which were semi-liquid, about twice daily. He also suffered from anorexia and slight headache. The abdomen had been increasing in size. Examination revealed ascites, but no masses or enlarged liver, or spleen. There was moderate rigidity and distinct generalised tenderness. Rectal examination was negative. His temperature ranged from 98° to 100° F., occasionally 101° F. The blood picture was that of moderate anæmia; the urine was normal; X-ray examination of the abdomen was negative. Von Pirquet's vaccination gave no reaction. The ascites had markedly decreased during the past three weeks and could now barely be demonstrated. Of especial interest was the history of the mother having miscarried nine times on various occasions before and after the birth of this boy, the only child. No signs or stigmata of lues could be demonstrated in the boy. The Wassermann reaction had not yet been done.

Congenital Deformity of the Thorax.—Dr. ARTHUR NEWLIN showed a baby, aged 6 months, showed in Dr. Hamill's service at the Polyclinic Hospital. The child was born at full term, normal, non-instrumental labour; parents living and well; two other children well; no dead children, no miscarriages. The deformity of the back was noticed shortly after birth; the child was well, suffering neither discomfort nor inconvenience. Examination showed distinct enlargement to the left, and continuous with the vertebral column, in the region from the twelfth dorsal to the second lumbar vertebra, an elevation of the spinal column extending to the left two inches. This was hard and firm, and the skin and subcutaneous tissues over it were somewhat thickened. The spines of the vertebrae seemed to be in an approximately straight line. There was no tenderness, no sign of inflammation or fluctuation about the mass. Von Pirquet reaction was positive. The X rays showed congenital absence of the right half of the twelfth dorsal vertebra and the twelfth rib on the right side. The left half of the twelfth vertebra was shown as a small wedge-shaped shadow occupying the space between the eleventh dorsal and the first lumbar vertebra on the left side. The absence of half of the vertebra on the

right and the presence of the wedge-shaped piece of bone on the left produced a distinct angle that was well shown in the X-ray plate, causing the mass on the left side of the vertebral column. On looking into the literature Dr. Newlin was surprised to find that this deformity had frequently been noted by anatomists, in most cases in the lower dorsal or upper lumbar regions. Cases showing the absence of whole or part of different vertebræ with accompanying ribs in the lower dorsal region were not uncommon.

Congenital Heart Disease.—Dr. E. E. GRAHAM showed a girl, aged 5 years, first child, who was born without instruments, was breast-fed four months, and walked at fourteen months, when she had bronchitis, at which time her heart disease was first noted. At nineteen months she had chickenpox; measles at two and a half years; lobar pneumonia affecting the right lung seven weeks ago, with crisis after almost three weeks. She was poorly nourished, below normal weight and height. The veins of the upper left anterior portion of the thorax were slightly distended; there was marked præcordial bulging; when at rest respiration was 28; pulse was regular, small, 121 per minute. The lips were somewhat blue and pale, hands and feet were cold, and fingers and toes were distinctly clubbed. Inspection showed a diffuse impulse in the mammary line in the region of the nipple; palpation showed an apex-beat a half inch within, without and above this spot. Relative cardiac dulness extended almost to the right mammary line, to the second costal cartilage, and to the left slightly beyond the mammary line. Absolute dulness reached the lower border of the second rib and almost to the left mammary line. A loud systolic murmur was plainly heard over the entire chest, loudest to the left of the sternum at the second rib. It was much less distinct in the axillary line, also less distinct at the angle of the scapula than higher up in the back, between the scapula and the spinous processes. The right side of the heart was evidently enlarged, more laterally than vertically. Cyanosis was only present after exertion. The pulmonary second sound was normal. There was no thrill on the pulmonary valve region. Dr. Graham believed the most probable diagnosis to be defect of the ventricular septum, patent foramen ovale, with probably abnormal origin of the great vessels. He based his diagnosis upon the comparatively slight cyanosis, the absence of a thrill, the hypertrophy of the right ventricle being sufficient to overcome the pressure in the left ventricle, the latter being little if at all enlarged, thus maintaining a fairly good pulmonary circulation. The latency of the condition, the slight cyanosis, and the recovery from a severe lobar pneumonia made this case of exceptional interest.

Dr. W. N. BRADLEY suggested the possibility of pulmonary stenosis.

Dr. J. H. McKEE referred to three somewhat similar cases which he had seen during the past year.

Dr. GITTINGS said that transposition of the great vessels could also be inferred from the fact that the cardiac dulness extended as far, or even slightly further to the right of the sternum than it did to the left, and that the maximum intensity of the murmur seemed, to his ear at least, to be situated about mid-sternum rather than to the left.

Amaurotic Family Idiocy.—Dr. KENNETH D. BLACKFAN reported a case of amaurotic family idiocy showing certain skeletal changes of achondroplasia of an atypical type. When first seen the characteristics of achondroplasia were manifest clinically, and X-ray pictures showed the skeletal changes of an atypical type. When the case came under observation six

months later there were symptoms suggestive of amaurotic family idiocy, and the ophthalmoscopic examination showed the pathognomonic picture of this condition. The skeletal changes of achondroplasia were even more marked than at the first examination.

Congenital Hypertrophic Pyloric Stenosis.—Dr. HARRY LOWENBURG reported the case of a girl, whom he had seen in June, then six and a half weeks old. Vomiting had begun at two and a half weeks and continued in spite of treatment. The baby lost weight, weighing 5 lb. 7 oz. when seen. In spite of all efforts the parents refused operation until the child had lost more weight. When seven weeks of age Dr. Stewart performed posterior gastro-enterostomy at the Pennsylvania Hospital. The pylorus was found absolutely impassable, thickened and hard. The stomach was enormously dilated and the intestines had completely collapsed. A small hard tumour mass was found at the pylorus. The child did well at once and weighed 13 lb. at twenty-two weeks. Dr. Lowenburg then discussed the question of diagnosis and treatment in full.

Dr. BRADLEY congratulated Dr. Lowenburg upon having the courage of his convictions; while we see some cases which suggest pyloric stenosis, making the diagnosis entails such heroic measures for relief that one must feel more than ordinarily the correctness of one's views. Posterior gastro-enterostomy is the operation of choice in these cases, as the extremely small calibre of the pyloric orifice, as viewed post mortem or at operation, makes it almost absurd to attempt any form of pyloroplasty.

Dr. GITTINGS thought that the amount of faecal matter passed in these cases was perhaps a more trustworthy index of obstruction than the frequency of vomiting. When the bulk of the stool was persistently minimal, it was of more significance than the cessation of the vomiting for twenty-four hours. The latter could occur in the presence of gastric dilatation when there was complete obstruction of the pylorus. Those remarks must not be constructed as an attempt to detract from the importance of spasm as a factor in many cases.

Dr. LOWENBURG said that when the presence of a tumour could not be definitely determined, the question of operation was a difficult one to decide. The only way to decide was by making careful daily observations of the infant's weight and strength.

Dr. ROSE HARRISON reported the case of an infant which died when five weeks of age, as operation was refused. Symptoms had appeared when the baby was two weeks of age. The autopsy showed hypertrophy of both mucous membrane and muscular coats of the pylorus and stomach. Only a fine steel probe could pass through the pylorus.

Dr. BRADLEY said that he had seen this case two or three days before death. He had agreed with Dr. Harrison in urging operation, but the family had refused. At the autopsy he was impressed by the extremely narrow pyloric orifice admitting only a fine probe.

Dr. LOWENBURG thought that Dr. Harrison's case was one of those that should undoubtedly have been operated upon. Dr. Lowenburg did not believe that the fact that many of these infants retained nourishment for twenty-four hours excluded complete stenosis of the pylorus, but on the contrary, this might be corroborative evidence of stenosis, being explained by the enormous dilatation of the stomach and the misstatements of parents in their eagerness to avoid operation. The absence of curds in the stools was also important evidence of complete stenosis.

Reviews.

THE CARE OF CHILDREN FROM BABYHOOD TO ADOLESCENCE. For the use of mothers and nurses. By BERNARD MYERS, M.D., C.M. With a preface by George F. Still, M.A., M.D., F.R.C.P. Second edition, revised and enlarged. Pp. xv + 174. London: Henry Kimpton, 1910. Price 1s. 6d. net; cloth, 2s. 6d. net.

THE success of this little work, which was reviewed in our February issue, is proved by the appearance within the year of a second edition. The principal addition is an appendix with a description of a simple method for making and sterilising the baby's milk without expensive apparatus. A list of books suitable for children has also been added.

DENGUE: GLANDERS (DENGUE-MUERMO). By Dr. D. JOAQUIN T. DUEÑAS. Barcelona: F. Seix, 1909.

THIS is a reprint of two articles contributed to the Spanish translation of Pfaundler and Schlossmann's 'Encyclopædia of Pædiatrics.' The first article is a careful description of dengue from the literature. The geographical distribution is more widespread than stated by Dr. Dueñas; the writer has seen the disease along the Pacific coast of South America and in the Andean Valleys, 2000 or 3000 feet above sea-level. Since Graham's pioneer work the mosquito has been convicted, on fairly reliable evidence, of spreading the parasite among men. Dr. Dueñas gives a good summary of these investigations. The article on glanders is less complete; such work as that of Dr. J. Bernstein and Mr. Carling on glanders in London, which has thrown much new light on the disease, has been quite overlooked.

A HANDBOOK OF INTESTINAL SURGERY. By LEONARD A. BIDWELL, F.R.C.S. Second edition. Pp. xiv + 215. London: Baillière, Tindall & Cox, 1910. Price 6s. net.

THIS book has been almost entirely re-written for the new edition. It gives a very complete and detailed description of all the commonly used methods of intestinal suture. The descriptions aim at telling a student how to practise and make himself perfect in the application of sutures to the intestine, it being recommended that the practice should be obtained on portions of bullock's intestine. All the different methods of suture and anastomosis which are of any practical value are very carefully described. There are also several chapters upon special operations in the abdomen. The last two chapters in the book deal with the preparation and after-treatment of operations in the human subject. The book is very fully illustrated throughout. We think that this book fulfils a useful function in surgical literature. It should certainly be read by those wishing to perfect themselves in the technique of abdominal surgery, and there is much valuable information between its pages.

STAFFORDSHIRE COUNTY COUNCIL: ANNUAL REPORT OF THE SCHOOL MEDICAL OFFICER FOR 1909. Pp. 99. Stafford, 1910.

AN exhaustive report is published by Dr. George Reid, Dr. Priestley, and four lady medical practitioners. Dr. Reid, the County Medical Officer of Health, has confined himself to writing a preface summarising the opinions of his staff, and deploring the loss of the grant for epidemic disease. He

leaves to Dr. Priestley, who is actually engaged in the work of inspection, the task of commenting on the enormous mass of ascertained facts; this is a practice to be recommended to other county officers, whose second-hand knowledge contributes materially to the dulness of their annual school reports.

Twenty thousand four hundred and seven-two children were inspected, eight minutes being devoted to the younger and ten minutes to the older children. Invitations to parents to attend the inspections met with but little response. On the other hand, great success has been obtained in persuading the parents to obtain treatment—90 per cent. of the cases are reported as having followed out the recommendations of the inspector. A height and weight table in the English and continental system is supplied, but unfortunately no comparison is made with the standard drawn up by the British Association.

Thirty-seven per cent. of the girls and 6 per cent. of the boys are verminous—a regrettably high figure, but one which shows improvement on last year's statistics, especially when it is remembered that no school nurses have been appointed to cope with this evil.

One hundred cases of ringworm were discovered among the 20,472 children examined, and from this it is calculated that there are about 400 cases among the school population of 75,000. Dr. Priestley thinks that tinea is of low infectivity, and supports his statement by remarking that different schools were affected in successive years, and that usually there were only one or two cases in each school.

Defective vision was more common than usual; 10·5 per cent. of the children tested showed vision of $\frac{6}{18}$ s and 16 per cent. of $\frac{6}{12}$. As is usual, the girls afforded the larger number.

Of 12,178 children examined, 513, or 4·2 per cent., were found to be mouth-breathers; 35·5 per cent. of the mouth-breathers were deaf. A preponderance of mouth-breathers was found among those suffering from enlarged tonsils and the presence of adenoids.

Severe dental caries (*i. e.* more than four decayed teeth) is recorded in 43 to 44 per cent. of the cases examined.

Hutchinson's teeth were noted in only one case.

Two hundred and forty-four cases of organic heart disease were discovered exclusive of 20 congenital cases. No details are given as to the valve affected, or to the necessity or otherwise of regulating school games and drills.

Of 20,474 children inspected, 34, or a percentage of 0·16, were found to be suffering from consumption of the lungs. No remark is made as to the stage of the disease, or the grounds on which the diagnoses were based. It is stated that about 5 per 1000 of our children suffer from consumption, and that the mortality rate is one tenth of the morbidity rate.

PROCEEDINGS OF THE NATIONAL ASSOCIATION FOR THE STUDY OF EXCEPTIONAL CHILDREN. Plainfield, New York, April, 1910.

TIME was when those imaginary lines drawn between kingdoms and known as frontiers could isolate nations from each other almost as effectively as lofty mountain-chains. The peoples on either side grew up in happy ignorance and equally happy contempt of their neighbours. To-day, however, we pass to and fro from this land to that, and find ourselves at home in all. We are citizens of the world, and, as cosmopolitans, we scarcely recognise an international boundary. So it has been with the sciences. Time was when

the "ologies" were securely walled off from each other. The biologist spent his vacation at home, and was sure he could gain nothing by a trip through the country of the geologists. The pathologist lived content in his own land, and cared not a fig for the dreary realms of the physiologist, where not a morbid process could be seen, north, south, east or west. To-day, however, we have become fraternal. We like to know how our neighbours fare, and, more remarkable still, we have found that they subsist on much the same food as ourselves, toil at the same work, and worship the same gods.

And yet the scientific barrier that remains with fewest gaps in it is, perhaps, that which separates the normal from the diseased. There are still people in plenty to whom these are as the land and the ocean—separate in being, unlike in form, different in essence. They see no transitions between them. Each is sharply marked off from the other. To these people, and, indeed, to all whose interest is in childhood, we recommend the volume whose title stands above. Ordinary children we know; they are common enough. Abnormal children we know—the idiots, the moral imbeciles, the epileptics. The two classes stand wide apart to right and left, and not even their shadows bridge the gap. But what are "exceptional children"? What is their merit that they should deserve a national association to study them?

Exceptional children are the children who, unnoticed by doctors, unheeded by educationalists, stand hand in hand linking up the normals with the abnormals. They belong to neither themselves. They are no more normal than they are abnormal. They are just exceptional. Some are bright, others are dull. Some are talented, others, perhaps, lack a quite every-day mental faculty. Until Maximilian Groszmann began to study them ten years ago no one had realised that in the minds of these children was hidden a key to the psychology (and therefore the education) of all children. And yet no one who reads the proceedings of this association, founded to commemorate Dr. Groszmann's work, can doubt the importance of recognising and studying exceptional children, or maintain that the normal and the diseased are not the two ends of one and the same chain.

THE FEEBLE-MINDED IN ONTARIO; FOURTH REPORT FOR THE YEAR 1909. By Dr. HELEN MACMURCHY. Toronto: L. K. Cameron, 1910. Pp. 50.

THIS report begins with a short account of the most interesting cases in the two institutions in Toronto—the Industrial Refuge and the Haven. The inmates are for the most part drawn from the class of the feeble-minded prostitute, or from persons who would have drifted into this class had they not been referred to these institutions by the authorities of the Maternity Hospitals. The inmates are taught remunerative manual work, which they learn to perform with wonderful success, and are also instructed in reading and writing. In some cases the improvement is so marked as to lead to the relatives insisting upon the inmate's discharge, with the usual result that another illegitimate and non-productive individual is thrown upon the rates. Dr. MacMurchy calculates that there are 1000 feeble-minded females in the province, and that there are 100 children born to these women annually. The report proceeds with an account of what is being done in other countries. Especially interesting is the achievement of New Jersey, where a training school has been established for those who wish to devote themselves to the teaching of the feeble-minded. The students actually teach defective children clay modelling, sewing, basketing, and other manual work. They also have the run of a completely fitted psychological laboratory, furnished with the

latest instruments of precision, and in addition of an anthropometric department in which are found a spirometer and a Smedley dynamometer.

In Germany there are 230 schools for defective children, with an attendance of 15,000. Some of these cases were investigated by E. Schlesinger, who found that parental alcoholism was the cause of only 2 per cent. of the cases, while 10 per cent. were due to neuropathic inheritance, including cerebral syphilis and tuberculosis. Deafness was very rarely the ætiological factor, while trauma at birth and atrophy of the thyroid were still more infrequent.

The rest of the report deals with what has been done in England from the legislative and medical standpoint.

THE PROBLEM OF THE CRIPPLED SCHOOL-CHILD. By E. D. TELFORD, F.R.C.S., Surgeon to the Manchester Hospital for Sick Children, Assistant Surgeon to the Manchester Royal Infirmary, Visiting Surgeon to the Manchester Residential School of Crippled Children. London: Sherratt and Hughes, 1910. Price 6d.

THE adoption of the provisions of the Elementary Education (Defective and Epileptic Children) Act, 1899, by the Manchester Education Committee, and the establishment of the Swinton Residential School for Crippled Children, are described and justified in an interesting pamphlet by Mr. E. D. Telford.

In the ordinary course of events the crippled child either attends school and neglects treatment, attends an out-patient department, or lives in the wards of a hospital and neglects education, or stays at home. In Swinton House sixty little cripples receive treatment and education.

These children are the victims, as may be expected, of (1) rickets, (2) infantile paralysis, and (3) tuberculosis of joints, and the training they receive is calculated to make them useful, self-supporting members of the community. Such children must otherwise be neglected, and unless supported by their families or relatives, ultimately may be reduced to beggary, their deformities becoming the objects of pity to the charitable public.

For the "progressive" cripple, as Mr. Telford mentions, the Poor Law Infirmary is the only hope, and far from satisfactory at that.

The school is conducted with the utmost economy. The milk supply is excellent and abundant, the school having its own cows on its own land. No operations are performed, and cod-liver oil is the only drug used.

A more interesting pamphlet on a more absorbing topic it would be difficult to find. It is to be hoped that Mr. Telford's excellent and brief description of a solution of a baffling condition of affairs will shortly be in the hands of all responsible for the care and education of school children.

TRANSACTIONS OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA. Third series. Vol. XXI. Philadelphia: 1909. Price not stated.

THIS volume contains the following articles of pædiatric interest: The Law of Degeneracy in its Relation to Medicine, by C. P. Noble; An Account of the Subcutaneous Injection of Sea-water and Results obtained, by T. Le Boutillier; Intestinal Perforation during Typhoid Fever, by J. H. Jopson and J. C. Gittings; A Case of Appendicitis in which *Oxyuris vermicularis* was found in the Appendix, by A. P. C. Ashburst; Purulent Meningitis second to Pan-sinusitis, Operation, Recovery, by W. G. Shields, jun., W. G. Spiller, and E. Martin; and Congenital Single Kidney, Practical Signification of the Condition, with Statistics, by J. M. Andrews.

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